# SHARE!
# COLLABORATIVE HOUSING

An easily replicable, cost-effective

## Solution to Homelessness for Mental Health Consumers

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# A Brief Description of SHARE! Collaborative Housing

SHARE! Collaborative Housing is an innovative, evidence-based program in Los Angeles County that permanently houses anyone with SSI within hours of their first desire to get off the street. SHARE! uses existing single-family houses in middle class neighborhoods. Disabled residents pay a portion of their benefit checks or other income for a furnished house, including utilities, a fully-equipped kitchen and laundry, as well as Cable TV and computers with high-speed Internet.

Unlike other Permanent Supportive Housing models, SHARE! Collaborative Housing does not depend on Section 8, vouchers or other government housing programs to pay for the housing units. There are no brick and mortar costs. The demand for rentable single-family houses in Los Angeles is low, compared to apartments, so houses are easily recruited to SHARE!'s program ensuring immediate placement throughout the County.

SHARE! Collaborative Housing does not require rental subsidies or move-in costs. SHARE!'s program is designed to address the most common barriers to housing, by not requiring security deposits/last month's rent, nor disqualifying people for poor credit; history of evictions; criminal history; current or past substance abuse; untreated serious mental health issues; or behavioral issues. SHARE! Collaborative Housing is a no-fail program: if someone is asked to move out of a house or chooses to leave for any reason, they are immediately placed in a different house, maintaining their housing as they make a fresh start. When it is safe to fail, people try new behavior and develop successful strategies for living.

SHARE! Collaborative Housing was developed as community stakeholder effort to house the estimated 25,000 people homeless disabled with mental health issues in Los Angeles. Following the planning process in the movie *Apollo 13*, the stakeholders, including mental health professionals, formerly homeless and currently homeless individuals, family members, academics, community members and others, looked only at existing resources available in the community to end homelessness among mental health consumers.

Within three months, the stakeholders had identified: a) the most frequent barriers to housing, b) many community resources that had rarely been used to overcome homelessness, and c) evidence-based practices that could support the endeavor. Mental health consumers on SSI had enough income to support themselves in housing in Los Angeles, when the housing was houses rather than apartments. Large single-family houses were well within the reach of those receiving SSI when they shared the house as a family. The academics on the committee discovered that housing two people per bedroom actually improved outcomes in studies done in other states. This practice also reduced the cost of housing making SHARE! Collaborative Housing affordable. Free self-help support groups in the community provided social support, listening skills, problem solving skills and 24/7 crisis response to their members. The faith community was available for miscellaneous needs as they arose. The first SHARE! Collaborative House opened for men on December 17, 2005 in Carson, CA. Today there are nearly 100 houses in the program including the original house.

Over the years, SHARE! has learned how to make SHARE! Collaborative Housing even more successful. Three-way conferencing homeless people on their first phone call to SHARE! with a homeowner who has a vacancy proved to be a winning strategy. The owners often drive to pick up the new resident and their belongings, so they can move in immediately. The addition of a Peer Bridger—a person with lived experience and sustained recovery from mental health, trauma, homelessness and/or substance abuse— funded by the MHSA Housing Trust Fund beginning in 2010 gave qualifying residents additional support which led to improved outcomes such as 26 percent of residents with SMI becoming employed within one year, and better retention in the first few months of housing.

# SHARE! Collaborative Housing is Evidence Based

SHARE! Collaborative Housing is an easily replicable, cost-effective program providing affordable, permanent supportive housing to disabled people in single-family houses. People with similar issues, such as vets, mental health consumers, etc. live like college roommates in the house which is fully furnished and equipped.

1. **Housing First and Recovery homes are best practice**
    a. SHARE! Collaborative Housing moves people into housing within hours of their first phone call for housing
    b. United States Interagency Council on Homelessness (USICH) endorses Housing First as a best practice
    c. Homeless mental health consumers and/or substance abusers are able to maintain housing without treatment (Tsemberis 2004)
    d. The federal government list Oxford House recovery homes within the National Registry of Evidenced-Based Programs and Practices (SAMSHA, 2011)
2. **A better neighborhood is a better quality of life**
    a. Moving a person into a better neighborhood has the health equivalent of increasing their income by $12,000 (Ludwig 2012)
    b. Moves people out of poverty – neighborhoods zoned for single family use have lower poverty and crime levels
    c. People in collaborative housing do not live in areas with drugs, prostitution and crime
    d. "Middle-class" lifestyle inspires hope, motivation to change
3. **Social networks improve outcomes**
    a. Neighbors who live next to a collaborative house take on supportive role to those in the house (Jason 2005)
    b. 40 percent of health and mental health wellness is determined by a person having adequate community support (Kindig 2014)
    c. Community support is posited to be the reason that people in developing countries recover from schizophrenia at nearly twice the rate that they do in developed countries (WHO 2001)
    d. Tangible social support is a major factor in determining whether someone with bipolar disorder is able to work and support themselves. Medication, doctor, symptoms, and whether people took their medication, were **not** predictors of successful employment (Canadian Health Reports 2004)
    e. Social relationships reduce mortality from all causes by 50 percent (Holt-Lunstad 2010)
4. **Self-help support groups propel people in recovery**
    a. Reduce the hospitalization of mental health consumers (Klein 1998; Landers 2011)
    b. Cut the rehospitalization of mental health consumers by 50 percent (Edmunson 1982; Galanter 1988; Kennedy 1990; Klein 1998; Kurtz 1988; NDMDA 1999; Raiff 1984)
    c. Reduce the number of days mental health consumers spent in the hospital by one third; significantly reduce the amount of medication needed to treat mental health issues (Edmunson 1982; Kennedy 1990; Raiff 1984)
    d. Reduce drug and alcohol abuse (Humphreys 2001; Kingree 2000; McAuliffe 1990; Pisani 1993; Watson 1997)
    e. Reduce criminal behavior (McAuliffe 1990; Watson 1997)
    f. Increase family resources and reduce family stress (Cook 1999)
    g. Increase consumer satisfaction (Hodges 2003; NDMDA 1999)

h. Increase social networks which improve outcomes (Holt-Lunstad 2010; Polcin 2010)
i. 70 percent of people in SHARE! Collaborative Housing regularly attend self-help support groups

5. **Outcomes improved with Peer Bridgers**—Peer staff, in sustained recovery, who have lived experience with mental health, trauma &/or substance abuse
   a. Reduce crisis events (Klein 1998; Landers 2011)
   b. Improve physical and emotional well-being (Klein 1998)
   c. Empowers residents (Rodgers & Teague 2007; Campbell 2003)
   d. Increases social network (Brown 2009; Nelson 2006)
   e. Increases housing stability and longevity (Susser, E. et al 1997; Dixon, L, et al 2009)

6. **Employment is more likely**
   a. 26 percent of people with severe mental health issues in SHARE! Collaborative Housing get jobs within one year as shown in the MHSA Housing Trust Fund dashboard
   b. People who receive Peer Services are more likely to become employed (Brown 2009; Hodges 2002)
   c. Income of residents doubles over a two year period (Jason 2010)

7. **House structure supports independence**
   a. Self-governing (Jason 2003; Tsemberis 2003)
   b. The absence of professional staff empowers people to develop their own rules and policies, learn to problem solve and assume positions of leadership (Jason 2003)
   c. Stay as little or as long as needed
   d. Shared housing mimics how Americans start an independent life, e.g. college roommates, moving out from Mom's and Dad's
   e. Two people per bedroom increases accountability (Jason & Ferrari 2010; Oxford House 2014) and makes the whole house available to everyone for living

8. **Financial self-sufficiency empowers residents**
   a. as people live without subsidies, they see that they have the resources they need to pursue a self-sufficient life
   b. Increases empowerment
   c. Increases self-esteem

9. **Stigma busting**
   a. Next door neighbors have more favorable attitudes and opinions of people in recovery (Jason 2005)
   b. People who know a person with mental health issues have less stigma (Crisp 2005)

10. **No NIMBY** (Not In My Backyard)
   a. SHARE! Collaborative Housing has had no NIMBY experiences in more than 100 houses.
   b. The US Supreme Court ruled in City of Edmonds v. Oxford House, Inc. that the Americans with Disabilities Act allows a family of disabled people to live anywhere a single family may live
   c. No increase in crime in neighborhoods with collaborative housing (Deaner et al. 2009)
   d. No decrease in home values (Council of Planning Librarians 1997; Ferrari et al. 2006; American Planning Association 1997)
   e. $185,000 to $200,000 is the cost per unit of NIMBY in project-based permanent supportive housing in California (Mayberg 2006)—SHARE! Collaborative Housing has no NIMBY costs

# SHARE! Collaborative Housing Meets the Needs of Residents

A 31-year-old homeless white man suffering from delusions and schizophrenia came to SHARE! Downtown. Within hours, SHARE! moved him into a SHARE! Collaborative House, where he is grateful to be able to bathe and eat regularly, wear clean clothes and attend self-help groups. Since he got housed, he has been able to consult with a psychiatrist and take medication that helps with the delusions. When he was on the street, medication made him so drowsy, that he feared for his life. He is happy that he has not gotten into a fight or had his belongings stolen from him in the house. He is now getting his ID card, and developing a budget to better manage the income he receives from Social Security.

A 60-year-old Asian woman with mental health and trauma issues contacted SHARE! because she was living in a domestic violence situation. She lived in SHARE! Collaborative Housing for almost two years before she decided to join SHARE!'s Volunteer-to-Job program at SHARE! Culver City. She is now employed full-time making $14 an hour and hopes to move into her own apartment soon.

A 52-year-old Latino man with schizophrenia who had been in and out of psychiatric hospitals and been homeless in his car in La Mirada and Pico Rivera, contacted SHARE! after losing his car and sleeping on the streets. The same day he contacted us, SHARE! housed him in SHARE! Collaborative Housing within blocks of where his family lives. He says that he has found the support he needs through SHARE! Collaborative Housing, his Peer Bridger and the self-help support groups SHARE! referred him to—Dual Recovery Anonymous and AA. He now has over a year of sobriety. He loves his house with the friendships and sense of community. He no longer feels isolated and alone.

An African-American 30-something bipolar woman moved into SHARE! Collaborative Housing because her mother's hoarding had become unbearable. She had been sleeping in the living room for years amidst clutter and filth. One of her most traumatic memories was when she had to go to the Emergency Room because a cockroach got stuck in her ear. The ER staff joked, as if she wasn't there, that they had never seen this before as they removed the insect. Two years after entering SHARE! Collaborative Housing, her life has dramatically improved as she has learned to do things that never happened in her family of origin, such as putting sheets on the bed and sleeping between them, eating fresh food, and having control over her personal space. She attends Adult Children of Alcoholics/Dysfunctional Families, Overeaters Anonymous and other support groups. She has set healthy boundaries with family members, lost 30 pounds, got full-time work and bought a car.

A young white schizophrenic woman stopped taking her medication when she became pregnant to protect the baby. SHARE! placed her in a SHARE! Collaborative House for women and children, where the owner took her under her wing. When the baby was born, the County deemed the mother unfit because she was not on medication for her mental health condition. The owner and other residents advocated to take responsibility of the baby until the mom could get stabilized on her meds again and were able to take mom and baby home.

Three months after moving into SHARE! Collaborative Housing a white 61-year-old woman with a mental health diagnosis started having major problems getting along with her housemates and was asked to leave. Her Peer Bridger supported her with a crisis plan and connected her to support groups such as Adult Children of Alcoholics and Dysfunctional Families that deal with trauma and conflict. The homeowner gave her the pro-rated refund for her rent which is part of the agreement with SHARE! Collaborative Housing, and with the support of her Peer Bridger, she moved to another SHARE! Collaborative House where she is happier and gets to start fresh with new housemates.

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